Ontario
Ministry of
Community and
Social Services

John Sweeney
Minister

Response to the Professional Advisory Board Steering Committee's Report and Recommendations

Ontario

Office of the Minister
Bureau du Ministre

Ministry of Community and Social Services
Ministère des Services sociaux et communautaires

Hepburn Block
Queen's Park
Toronto, Ontario
M7A 1E9
416/965-2341

Édifice Hepburn
Queen's Park
Toronto (Ontario)
M7A 1E9
416/965-2341

August 4, 1988

Dear Colleagues:

As you know Part VI of the Child and Family Services Act, (Extraordinary Measures) has not yet been proclaimed. It was delayed to allow for further consideration of some very sensitive issues addressed in it. To assist with the difficult task of implementation planning, the Professional Advisory Board Steering Committee was established. The Committee was chaired by Dr. Benjamin Goldberg, Director of Treatment, Training and Research at the Children's Psychiatric Research Institute in London. This multi-disciplinary Committee consisting of experts from the field, carefully reviewed all aspects of Part VI and submitted its report and recommendations to the Ministry in September of 1986.

My Ministry has carefully reviewed all of the recommendations made by the Committee, and is pleased to present the attached response. The response is based to a great extent on the Committee's extensive report and recommendations and on numerous responses received from the field during consultation on the report. I believe that the policy my Ministry has developed will provide for the best interests, protection and well being of the children we serve.

In order to proclaim Part VI, it will be necessary to introduce amendments to the Child and Family Services Act. My staff are currently working on these. Following enactment of the necessary amendments, I expect to proclaim the provisions regarding Secure Treatment and Psychotropic drugs in the summer 1988 and the remaining unproclaimed provisions in the winter 1988-89.

I wish to thank those of you who took part in this consultation process and I am sure that the combination of our efforts will continue to enhance services provided for children.

Questions regarding the response should be directed to: Gail Desabrais, Policy Analyst, Children's Services Branch (965-6230).

Sincerely,

John Sweeney
Minister

Attachment

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Table of Contents

		Page
SECTION 1	INTRODUCTION	3
SECTION 2	OVERVIEW	4
SECTION 3	THEMES	5
SECTION 4	RESPONSES TO EACH RECOMMENDATION	8
SECTION 5	APPENDIX	29

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SECTION 1: INTRODUCTION

Background

The Child and Family Services Act, 1984 was enacted in December 1984 and proclaimed (in part) in November 1985. Proclamation of certain sections of Part VI (Extraordinary Measures) was deferred pending further implementation and policy work by the Ministry and its funded agencies. A Professional Advisory Board Steering Committee[1] was established to assist the Ministry in preparing for full implementation of Part VI. The Steering Committee released a document in September 1986 entitled "Part VI: Extraordinary Measures, Implementation Issues and Recommendations" which included forty-one recommendations. The Steering Committee's document was circulated for response to "umbrella" associations (e.g., Ontario Association for Community Living and Ontario Association of Children's Aid Societies), advocacy groups, children's service providers and interested members of the general public. Over thirty written responses were received by the Steering Committee and the Ministry. In addition the committee met with a number of groups and received verbal feedback.

Ministry Response

The Ministry's response to the Professional Advisory Board Steering Committee's report and recommendations is contained in this document. First, a broad overview is provided to place the discussion of extraordinary measures in a context. The next section summarizes those themes which created the widest discussions and had the most differences of opinion. These areas are: the role of the Professional Advisory Board, psychotropic drugs, and manual restraint. The main body of the document provides a specific response to each recommendation. Many of the Steering Committee's recommendations have been accepted either in whole or in part. Where a recommendation has not been accepted, a rationale and an alternative method of resolving the problem is provided. The following format is used in response to each recommendation:

RECOMMENDATION BY PABSC

MINISTRY RESPONSE

RATIONALE

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[1] See Appendix A for a list of the Steering Committee members.

SECTION 2: OVERVIEW

The uses of extraordinary measures with children are, unfortunately, necessary at times. The provisions of Part VI of the Child and Family Services Act have been designed to safeguard the best interests of children for whom intrusive procedures, secure isolation and psychotropic drugs have been recommended. The Canadian Charter of Rights and Freedoms[2] and the principles of the CFSA (best interests of the child and least restrictive appropriate alternative) provide a framework of powerful safeguards for these children.

In addition to the above noted safeguards, the Ministry's objectives and goals provide overall directions and values for placing the regulation and uses of extraordinary measures in a context. The Ministry's primary focus is to support rather than replace the efforts of individuals and families. One Ministry objective is to:

> **Provide services to children that ensure a safe, healthy, nurturing and stimulating environment to foster growth and development**

One strategy for reaching the above objective is to develop policies and mechanisms to facilitate a more flexible community-based service system for children. It is expected that the new legislative framework provided by the Child and Family Services Act, subsequent emerging regulations and their interpretation by the courts will provide the basis for the implementation of this strategy. The legislation will allow for an appropriate selection of programs to be provided by a single agency. The programs will be tailored to support the child and/or family without labelling either and without having to remove the child from the family or community wherever possible. Having established the framework, the Ministry will endeavour to ensure that appropriate policies and state-of-the-art programs are in place.

The Ministry supports the current shift away from residential care facilities and segregated services towards the objectives of normalization and community services for all children. In addition efforts to promote behaviour change through community approaches to treatment, for primary prevention programs, and for research into alternatives to intrusive procedures are supported. To reach the objectives of normalization and community living for all children (through reinforcing personal dignity and independence) strong primary prevention programs and state-of-the-art treatment procedures must work together to reduce the numbers of seriously disturbed children requiring intensive treatment. Since extraordinary measures are rarely used as part of 'community living', one measure of the success of the objectives would be a

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2 The Charter guarantees to all Canadian citizens certain fundamental rights and freedoms. These freedoms and rights may only be curtailed if the limits are "such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society."

reduction of the overall uses of extraordinary measures. This might suggest either that alternative treatment procedures had been developed whereby seriously disturbed children could stay in their communities or that fewer children were becoming seriously disturbed in the first place (or some combination of the two).

While a reduction of the uses of extraordinary measures may be accounted for in other ways, their overall reduction is more consistent with children being able to remain in their communities. It is therefore not only important that the safeguards provided for by Part VI regulate the uses of extraordinary measures, but also that the policies, programs, and guidelines behind these safeguards work toward the reduction of the uses of these measures.

The provisions of Part VI are there to safeguard children when extraordinary measures are necessary. In addition to regulating the uses of extraordinary measures, a further and more lasting safeguard for children is the overall reduction of the need for any extraordinary measures. The role of the Professional Advisory Board is to advise the Minister on matters respecting extraordinary measures, which may include the important matter of finding alternative treatment procedures. Staff development and training programs, in addition to teaching staff how to safely use extraordinary measures, should also be teaching staff alternatives, so that fewer uses become necessary. While this response on the whole addresses the regulation of extraordinary measures when they are necessary, an underlying theme--consistent with community living for all children--is to strive for ways, through legislation, education and prevention, to reduce the need for extraordinary measures.

SECTION 3: THEMES

ROLE OF THE PROFESSIONAL ADVISORY BOARD

Part VI gives the Minister authority to establish a Professional Advisory Board (PAB) which shall, at the Minister's request, advise on (and investigate and review) matters involving the use of psychotropic drugs, intrusive procedures and secure isolation. Additionally any person may request that the Minister refer a matter respecting secure isolation, intrusive procedures or psychotropic drugs to the Professional Advisory Board for investigation and review. The Steering Committee, however, proposed through a number of recommendations (e.g., 19, 26, 36, 37, 38) that the role of the PAB be an authoritative one with regulatory or monitoring powers. This proposal would be a major change from the design of Part VI. It appeared to be based on the premise that the most knowledgeable body of experts would be situated in the PAB and that therefore the PAB should be the body which makes decisions with respect to approvals for the use of certain procedures. This would be especially so for high risk intrusive procedures. This proposed role was a consistent theme throughout the report and influenced a number of other recommendations.

The present statutory safeguards in Part VI are derived from the Ministry (approving settings), the review teams (approving specific procedures) and the PAB for expert professional advice to the Minister. This design is sound. The Minister (by delegation to the Area Office) approves settings for the use of secure isolation, intrusive procedures and may set any conditions and limitations on the approval. This means that if the PAB advises that certain procedures require more safeguards than others, that the Ministry can impose this at the time of approving the setting. In addition the review team must also approve specific intrusive procedures or uses of secure isolation. Guidelines for review team approvals may differ depending on the particular procedure. This design has sufficient control to provide the necessary safeguards and is flexible enough to increase those safeguards.

Role of the PAB to remain Advisory

If the PAB were to take on the authority and responsibility of approving settings and/or specific procedures there would be no body to review (or consult with over) contentious issues. The PAB could certainly not review its own decisions. Moreover the roles of the review teams and the Area Offices would be compromised and diluted. If more rigorous scrutiny is required for certain procedures, this can be accomplished through tighter guidelines and approval mechanisms by the Ministry and the review team before approving such procedures. The rationale for an independent, advisory review board is strong. It is necessary to provide a check and balance to the approvals given by the Ministry and review teams. The proposed role of the PAB has therefore not been accepted in the Ministry response and a number of recommendations have been altered to remain consistent with the advisory nature of the role of the PAB.

Additionally since the Steering Committee's recommendations appeared to be based on the overall theme that the PAB's role was to be an authoritative one, their recommendations with respect to the review teams had the effect of giving those teams less authority than they otherwise might have had. Although Part VI requires only one external member to sit on a review team, it also states that the Minister can set any conditions on a setting before approving it for the use of intrusive procedures. It is possible therefore for the Ministry to decide that for certain intrusive procedures, a review team approval should, as an example, contain at least two external members to the agency. This could be one way of strengthening the approval process, if that is thought to be necessary for certain procedures. Given that the role of the PAB will remain an advisory one the review team's role will be strengthened through administrative guidelines to ensure that the safeguards intended by Part VI are carried out.

PSYCHOTROPIC DRUGS

Broad review of the section on psycotropic drugs is recommended.

The requirements of the section on psychotropic drugs have created some confusion and controversy. The requirement to disclose 'any' risk as part of the consent procedure was interpreted by some to be too cumbersome and out of line with preferred practice of physicians. The Ministry response to this situation (see recommendation #11) brings the requirement more in line with preferred practice. Additional concerns regarding the relationship of the physician, the client and the service provider (see recommendation #10) and the difficulties in providing emergency treatment via psychotropic drugs to a 16 or 17 year old who lacks capacity and a proxy consent (recommendations #14-16) make this section one which is being recommended for a broad review after the next round of amendments. It is anticipated that a working committee will be struck with the OMA (among other groups) to begin looking at the difficulties in this section.

MANUAL RESTRAINT

Background

The Steering Committee's proposed definition of intrusive procedure (recommendation #17) met with a fair amount of resistance, in part, because it was broad enough to include all forms of manual restraint as an intrusive procedure. This would mean that virtually every service provider would be subject to Part VI regulation. Unlike most other procedures defined as intrusive on the proposed schedule (recommendation #18), manual restraint is used by many different service providers in different ways. In addition, the other intrusive procedures listed on the schedule are mostly used during behavioral treatment programmes, whereas manual restraint is used during a wide variety of treatment approaches. Its widespread use has been cited as one strong reason for not including it as an 'extraordinary' measure. On the other hand, its 'inherent' intrusiveness has been cited as strong evidence of the necessity to include it in Part VI.

Recommendation

The Steering Committee and the sub-committee recommended that any uses of manual restraint be considered an intrusive procedure and therefore subject to Part VI provisions. These recommendations have been carefully considered, however they have not been accepted. The Ministry's position (see also recommendation #17) is that only 'planned manual restraint' will be prescribed as an intrusive procedure for the purposes of Part VI. Both emergency and custody uses of restraint will continue to be regulated outside of Part VI. In

brief[3], the basic rationale for this position is that manual restraint is a different procedure depending on its context. Both the legal and professional literature clearly distinquish between the different applications (planned, emergency and custody) of this procedure. The regulation of these dissimilar applications in a similar manner would lead to ineffective and inefficient monitoring systems. A regulatory scheme which treats very different situations similarly, failing to recognize the importance of different contexts, is too rigid. A regulatory structure which encompasses the child's rights and needs within a context is seen as most strongly promoting and protecting the best interests of the child.

SECTION 4: RESPONSES TO EACH RECOMMENDATION

RECOMMENDATION

1. **The service provider be required to seek a consent to release of information from the parent or child 16 years of age or older, if proposing the use of an intrusive procedure to the review team.**

MINISTRY RESPONSE

Accept.

RATIONALE

This recommendation is part of the Steering Committee's proposed two-stage process for obtaining consent to use an intrusive procedure. It has the following benefits:

1) It supports present, preferred practice by requiring consent before an outside professional reviews file material.

2) It demonstrates to the review team that the service provider has discussed the proposed use of an intrusive procedure with the "consent-giver".

3) It is efficient since the review teams will only be in the position to review files where consent-givers have had some preliminary discussion of the proposal. In this way the review teams will not review files where the "consent-givers" would not have given consent even to a consideration of the procedure.

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3 Please see "The Regulation of Personal Restraint under Ontario's Child and Family Services Act: A Policy Dilemma" for a detailed analysis of this question.

RECOMMENDATION

2. **The review team canvass with the service provider the extent to which the service provider has discussed the proposal with the parent or child 16 years of age or older, if the parent or child is not present at the review team's deliberation.**

MINISTRY RESPONSE Accepted in principle.

RATIONALE Since both recommendations #1 and #3 have been accepted the "consent-giver" will have been through a two-stage consent procedure before any consent is given to the use of an intrusive procedure. This should assure discussion between the service provider and consent-giver. If the consent-giver is not at the review team's meeting, given that the structure of the review team includes the service provider's staff, the ability to 'canvass' already exists. Recommendation #2 appears to be preempted by recommendations #1 and #3, and unnecessary given the structure of the review teams.

RECOMMENDATION

3. **The consent for the intrusive procedure be sought <u>after</u> the review team has considered the service provider's proposal, so that the parent or child (16 years of age or older) has the benefit of the review team's recommendation.**

MINISTRY RESPONSE Accept.

RATIONALE This recommendation ensures that the consent-giver has the opportunity to take into account the review team's deliberations before giving consent to the intrusive procedure. This is consistent with the consent-giver being "reasonably informed as to the nature and consequences of the consent" and with the purpose of Part VI.

RECOMMENDATION

4. **Section 126(2) be amended to clarify the intent of the legislation, as follows:**

"The consent referred to in subsection (1) <u>may be in writing</u>, and should be based upon disclosure that identifies the specific psychotropic drug."

MINISTRY RESPONSE Not accepted.

RATIONALE Since psychotropic drugs were included in Part VI, this type of intervention with children was seen as extraordinary enough to require some special safeguards. One such safeguard is the nature of the consent required under Section 126(2). The proposed recommendation is a more 'general' consent which is inconsistent with the safeguards intended in Part VI. It is recognized that this runs somewhat counter to the preferred practice of the medical profession, however, as long as psychotropic drugs are included in Part VI, the intent is to protect children in care with a more rigorous consent procedure than is apparently required for the general public. There would otherwise be no reason to include psychotropic drugs in Part VI.

RECOMMENDATION

5. **Consent to the use of an intrusive procedure be formalized by a signed document.**

MINISTRY RESPONSE Accept.

RATIONALE This recommendation is consistent with the intent of Part VI. It acts as an additional practical safeguard to help ensure that consent has in fact been given and that the consent was "informed".

RECOMMENDATION

6. **Every service provider be required to develop written policies and procedures with regard to the inclusion of consent procedures for the administration of psychotropic drugs and intrusive procedures.**

MINISTRY RESPONSE Accept.

RATIONALE A regulation similar to the one for secure isolation [O. Reg. 550/85, S. 41(1): "Every service provider shall develop and maintain written policies and procedures with respect to the use of a secure isolation room..."] should be drawn up for intrusive procedures and psychotropic drugs. These policies and procedures will include consent procedures. Requiring the development

and maintenance of written policies and procedures by those service providers who intend to use intrusive procedures or psychotropic drugs will increase the likelihood of the safeguards provided for in Part VI being upheld.

RECOMMENDATION

7. Section 202(i) be broadened to read "prescribing drugs, classes of drugs or combinations of drugs as psychotropic drugs".

MINISTRY RESPONSE Accept.

RATIONALE This recommendation broadens the ability to regulate from specific drugs (or combinations) to classes of drugs thereby ensuring that the regulatory schedules will be able to reflect the rapid changes in more up-to-date pharmacology. This is consistent with Part VI in that it strengthens the child's protection. (Note: This was proposed as an amendment in the Act to Amend the Child and Family Services Act', Bill 107).

RECOMMENDATION

8. For the purpose of Section 126, "psychotropic drugs" shall be defined in regulation as:

.1 Medication that is intended to affect or that has a primary effect on mental processes, or is administered to change mood, thinking or behaviour, and any medication, from any class that is prescribed for the same purpose as an anti-psychotic, anti-depressant, sedative, hypnotic, anti-anxiety, anti-manic, or hyperkinetic drug, including, but is not limited to, those drugs appearing in schedule 1, and

.2 Without limiting the generality of the foregoing, any drugs of other classes that are used to affect mental processes.

MINISTRY RESPONSE Accept in principle. This definition can be used as a working definition by the PAB and in training sessions.

RATIONALE The psychotropic drug schedule, as accepted in recommendation #9, is sufficient to inform service providers, physicians, and Ministry personnel with

respect to which drugs are considered psychotropic. The proposed definition is somewhat cumbersome and there is no compelling reason to have a regulatory definition, given the regulatory schedule. The schedule prescribing which drugs are psychotropic, updated regularly by the PAB in consultation with appropriate medical consultants is clear, concise and informative.

RECOMMENDATION

9. **Specific drugs be identified in a psychotropic drug schedule to the regulations; this schedule should be revised and updated regularly on the recommendations of the Professional Advisory Board.**

MINISTRY RESPONSE Accept.

RATIONALE An up-to-date schedule will provide clarity for service providers thereby making their responsibilities with respect to psychotropic drugs easier to fulfill.

RECOMMENDATION

10. **For the purpose of Part VI of the Act, "A child in service provider's care" (S. 126) be defined to mean those receiving service on a 24-hour basis, on a daily or regular basis, or on a support service basis, where the program provided by the service provider is part of the individual program (care) plan for the child and the service provider is involved in the administration of a psychotropic drug.**

MINISTRY RESPONSE Not accepted.

RATIONALE

1) The proposed definition of "child in service provider's care" would not only effect this section, but other sections of the CFSA as the term or like terms are used throughout the entire Act. This would require an analysis of its effect throughout the Act and such a broad review is not seen as necessary to clarify this issue.

2) The section depends on the physician's relationship to the service provider, not the sweep of the phrase "child in the service provider's care". If the physician is the service provider, is working for the service provider, is a consultant to the service provider, or if the service provider can choose which physician to use, then s. 126 applies, no matter the extent of the 'care'.

The service provider has some authority or control in these cases and hence, the section will apply. If, however, a parent and/or child consents to a drug being administered by a physician who is independent of any relationship with a service provider, then that transaction is only between the physician and the parent/child and falls outside of s. 126 and within regular medical procedures, practices and regulations.

The only time an issue will arise is when a service provider is asked to actually dispense a psychotropic drug to a child during any type of 'care', when the drug has been prescribed by a totally independent physician. (If a parent or child dispenses the drug on their own before arriving or after leaving 'care' (e.g. speech therapy), there is nothing the service provider can do to 'permit' or prevent this from occurring.) In the case where the service provider is asked to dispense the drug, the service provider will require confirmation from the independent physician that consent pursuant to s. 126 has been given before they can administer the medication. If confirmation is not forthcoming the service provider may not administer the psychotropic drug.

RECOMMENDATION

11. The word 'Any' in Section 126(2)(c) be changed to 'material', and that 'material' risk be specified in regulation as follows:

.1 Materiality is to be determined by the probability of the possible risk and also by its seriousness should it occur; and

.2 Materiality is associated with the particular drug and the child's special circumstances; and

.3 Any risk to which the particular child or family, would likely attach significance in determining whether or not to consent to the proposed drug to be considered "material".

.4 Any risk to which a reasonable person would likely attach significance in determining whether or not to consent to the proposed drug.

MINISTRY RESPONSE

Accept in principle however implementation to be achieved by replacing 'any' with 'the' in the legislation. There is no need for a change in regulation. (Note: This amendment has been included in the 'Act to Amend the Child and Family Services Act', Bill 107).

RATIONALE Replacement of the word 'any' by 'the' provides a simpler solution. This requires no definition of material nor does it require all risks to be disclosed. Risks will need to be disclosed in line with the common law.

RECOMMENDATION

12. **The Ministry liaise with the Ontario Colleges of Nurses, Community College programmes for support services, and other relevant professional disciplines, to develop a curriculum to train staff in ministry programs in the judicious and appropriate use of psychotropic drugs.**

MINISTRY RESPONSE Accept.

RATIONALE This is an appropriate and practical way of improving knowledge with respect to the appropriate use of psychotropic drugs.

RECOMMENDATION

13. **The ministry works with the Ontario Medical Association and the College of Physicians and Surgeons, to acquaint physicians with the intent of the Act and the implications of the Act for their practices.**

MINISTRY RESPONSE Accept.

RATIONALE Better informed physicians (this recommendation), and service providers (recommendation 12) should mean stronger overall treatment plans for children and therefore the general well-being of children should be improved.

RECOMMENDATION

14. **The Minister appoint a substitute consent panel drawn from the membership of the Professional Advisory Board, which would have the power to give substitute consent or refuse consent where psychotropic medication is being proposed on an emergency basis for a 16 or 17 year old who lacks capacity and proxy consent.**

15. **The 72-hour limit for emergency use of psychotropic drugs is changed to 5 days (120 hours) for 16 to 17 year olds who lack capacity and a proxy consent.**

16. **The Minister through the Child and Family Services Act, enable the service provider to obtain substitute consent in an emergency where a child 16 years of age or older, lacks capacity and no proxy consent is available.**

MINISTRY RESPONSE

Not accepted. Given the common law, the anticipated Guardianship legislation and the rare occurrence of this situation (as noted in the PABSC document), the establishment of a new substitute consent panel is not necessary at this time.

RATIONALE

In the very rare situations where a 16 or 17 year old continues to lack capacity and a proxy consent after 72 hours, the service provider must, at that point, rely on the common law. Although the CFSA states that the administration of a psychotropic drug shall not continue unless consent is given, if its discontinuance would endanger the life or limb of the client, then the physician may continue to administer the drug. The physician would be required to rely, at that point, on the same provisions he or she would rely on for an adult in the same situation. The paramount objective of the CFSA is to promote the best interests, protection and well-being of children. The standards for administering psychotropic drugs in emergency situations must be met; however, if the time limit has been reached and a danger to life or limb still exists, the standard must then revert to a common law standard in that the physician must still respond to the situation.

RECOMMENDATION

17. **An amendment be made to Section 108(b) to define an "intrusive procedure" to mean an action or series of actions resulting in restrictions of freedom of movement, or reduction of visual, auditory or physical stimulation, or pain or discomfort, or the risk of pain or discomfort, and that action is designed to affect a specific behaviour identified as impairing the child or causing him or her to suffer; employed with the goal of modifying or controlling the behaviour; and integrated into the child's overall treatment plan, or used as an emergency measure.**

MINISTRY RESPONSE

Not accepted.
Section 108(b) to remain the same.

RATIONALE

The Steering Committee's definition is too broad. It captures activities well beyond the intended scope of Part VI. For example, having a child leave a group activity and sit in an adjacent room until they are ready to return might well be a "reduction in visual (and/or auditory) stimulation", however, in the vast majority of circumstances this would be considered common child-rearing practice and would not be considered intrusive. These actions, however, would be caught by the Steering Committee's definition. A very large number of benign behavioral and disciplinary actions would be caught by the Steering Committee's definition, even though this was not their intent. The Steering Committee's definition for section 108(b) would act to prohibit all of those procedures that satisfy the definition (by virtue of s. 125(1)). That is, only those procedures appearing on a schedule of intrusive procedures could be considered for approval by the Ministry (s. 124) and by the review teams (s. 125). The Steering Committee's definition, therefore, would require a very extensive schedule ranging from the most intrusive procedures to benign activities--all of which would require Ministry approvals and review team approvals. This would clearly not be an efficient or effective use of limited resources nor was it the intent of Part VI to be that broad.

The present definition provides clarity and some needed flexibility. It is clear since only those procedures which would be listed on the prescribed schedule (in the regulations) would be subject to Part VI provisions. This will provide for both consistency and clarity between service providers and the Ministry since both will always know exactly which procedures are considered intrusive. The concern that some procedures may not be caught by the schedule also holds for the Steering Committee's definition, since there will always be some procedures which are considered 'on the line' no matter what scheme is used. Also as noted by the Steering Committee any use of a procedure which harms children will be caught by the abuse sections of the CFSA and federal criminal legislation (except some of those regulated by Part VI.)

The definition also provides the flexibility to deal with the complex issue of manual restraint in a 'graduated' manner. The Ministry position is that initially only 'planned manual restraint' will be considered an intrusive procedure. While this does not exclude the possibility of other forms of restraint being included as intrusive procedures, more compelling rationale is

necessary before additional forms will be included.

RECOMMENDATION

18. Specific intrusive procedures be listed in a regulatory schedule that is revised and updated on a regular basis on the recommendation of the Professional Advisory Board.

MINISTRY RESPONSE Accept.

RATIONALE A regulatory schedule, revised on a regular basis, is essential given that the schedule will be the entire list of procedures subject to the intrusive procedures provisions. It is an appropriate role for the PAB to recommend which specific procedures should be on the intrusive procedures schedule.

RECOMMENDATION

19. Approval for high-risk intrusive procedures be given only after special review on a case-by-case basis, by the Professional Advisory Board.

MINISTRY RESPONSE Not Accepted.

RATIONALE The PAB cannot approve a procedure and then review its own approvals. (See recommendations #26 & 37) At proclamation the review team will have authority to approve intrusive procedures on a case-by-case basis. The Minister may set <u>any</u> conditions or limitations when approving a service provider to use high risk procedures. A condition will be set on any service provider approved to use high risk procedures that their review team members <u>must</u> include at least two external professional members approved by the Ministry. This will ensure some additional professional input (which was the spirit of the Steering Committee's recommendation) and maintain the role of the PAB as advisory so that it may be used to review any complaints.

RECOMMENDATIONS

20. After the first use of emergency (preventative) restraint on any child, continued use of the procedure be permitted only in accordance with the Section 125 (intrusive procedures) mechanism.

21. Apart from initial emergency use, all service providers must be approved under Section 124(1), to use restraint and that such approval be conditional upon:

.1 Its use being limited to situations where the child is physically harming self or another, or clearly about to do so, or where the child is engaged in severe property damage, and

.2 All appropriate staff of the service provider have been given sufficient ministry approved training in the use of manual restraint.

MINISTRY RESPONSE Not accepted.

RATIONALE Only planned manual restraint will be regulated under Part VI. The use of manual restraint with children in emergency situations will be monitored by each agency's clinical monitoring system and regular reviews by area offices (Please see earlier discussion of manual restraint at page 6 and recommendation # 17 for further elaboration.

RECOMMENDATIONS

22. The conditions that justify and are prerequisite to the use of intrusive procedures be defined by behavioural standards.

23. Every service provider be required to develop written specifications for intrusive procedures within the overall program plan for the child.

24. No intrusive procedure be approved without a complete medical and environmental assessment that indicates the (i) the child's behaviour is not due to a medical condition or medication, or that the condition does not contraindicate the proposed treatment, and (ii) the behaviour is not the function of an inappropriate environment, staffing pattern or approach, or program.

MINISTRY RESPONSE Accepted in principle. The general intent of these recommendations can be implemented by inserting these ideas in the guidelines used by the Review Teams before approving an intrusive procedure. That is, before the review would approve a specific procedure they would require that:

(1) behavioural standards are used to define the necessary conditions prerequisite to the use of intrusive procedures (recommendation 22);

(2) there are written specifications for the intrusive procedure within the overall plan for the child (recommendation 23), and;

(3) medical and environmental assessments must be completed (recommendation 24).

RATIONALE These procedures represent sound professional practices and are consistent with the spirit of Part VI.

RECOMMENDATION

25. **In order to ensure ethical implementation of intrusive procedures, standards be approved for the use of behavioural procedures in ministry facilities, and that consistent standards be developed for use in the ministry community-based programs.**

MINISTRY RESPONSE Accept in Principle

RATIONALE These standards will provide criteria by which to assess service providers who intend to use intrusive procedures and will also assist in providing consistency across the province. The extensiveness and form of the actual standards or guidelines will be reviewed and a plan established prior to proclamation of Part VI.

RECOMMENDATION

26. **An approval process for the use of intrusive procedures be delegated by the minister to the Professional Advisory Board and that such approval be both procedure and setting specific. The Professional Advisory Board acts as the professional review aspect of the approval process in conjunction with appropriate area and regional staff of the Ministry.**

MINISTRY RESPONSE Not accepted. The role of the PAB as an independent advisory board should be preserved. A delegation of authority from the Minister to the PAB would alter its intended function and status.

RATIONALE The PAB must remain independent since it is vested with the authority, at the Minister's request, to investigate and review the matter of the use of an intrusive procedure. If the PAB had authority to

approve the use of an intrusive procedure as suggested in the recommendation, then another body would be required to review that decision. The PAB could clearly not review and investigate its own approval. The PAB is designed as an independent safeguard and advisory board to the Minister and as such must remain independent from the decision-making process.

When the Ministry approves settings for the use of intrusive procedures, guidelines will stipulate that an expert professional (not members of the PAB) must be used to advise the Area Office on these approval requests. This will provide the Ministry with additional professional input before approving settings. The authority to approve specific intrusive procedures is vested in the Review Teams. A condition of the Minister's approval of the setting can be that the review team is required to have more than one external professional as a member for approvals of certain procedures.

RECOMMENDATION

27. **A process should be initiated by the Ministry whereby all staff who would be responsible for designing, supervising or implementing intrusive procedures, should be certified by an affiliated body or bodies. This process should be implemented within three years.**

MINISTRY RESPONSE Accepted in principle.

RATIONALE This has potential to offer additional safeguards for the use of intrusive procedures. It could be regulated by including it as a condition for approval by the area office and by review teams for specific proposals. However, a feasibility study is necessary to determine a number of questions before proceeding with this recomendation. It is not at all clear how many staff this would encompass nor the types of certification that would be required.

RECOMMENDATI0N

28. **Section 121(1) be amended as follows:**

.1 **...(1) no service provider or foster parent shall isolate in a locked place a child who is in his or her care or permit the child to be isolated in a locked place, except in accordance with this**

section, section 125 (intrusive procedures) and the regulations.

.2 Confinement timeout be encompassed in the definition of "intrusive procedure" in Section 108(b)(iii); namely a "procedure that is prescribed as an intrusive procedure".

.3 In order to provide appropriate safeguards for confinement timeout, the Minister set out under Section 124 conditions and limitations for confinement timeout in accordance with standards for behavioural treatment and training.

MINISTRY RESPONSE

Accept in principle. Amendment is being considered to the CFSA that would give the Minister authority to approve a service provider for the use of a secure isolation room for the purpose of restraint or planned intervention, subject to statutory limitations, the regulations and the review team's approval. While the safeguards are extensive, the amendment does allow for the use of CTO in limited situations. The amendments also make all uses of secure isolation, whether planned or emergency, subject to review team approvals, thereby accomplishing recommendation 28.2.

RATIONALE

The use of a locked isolation room as a last-resort means of stopping self-injurious or severely socially maladaptive behaviour of autistic, brain-damaged and developmentally handicapped children is presently seen as necessary for the rehabilitation of these children. Until some other method of checking this extreme behaviour is available, a total ban on CTO does not appear to be in these children's best interests, as even more intrusive methods may be necessary to stop their behaviour if CTO is not permitted. Therefore, a regimen of statutory and strict administrative control on the use of 'CTO' is necessary until alternative forms of treatment are discovered.

RECOMMENDATION

29. That the following terms be defined in regulation:

a) "Psychosurgery": surgery performed on normal tissues of the brain of an individual who does not suffer from physical disease, for the purpose of changing or controlling the emotions or behaviour of such an individual, or on diseased brain tissue of an individual, if the primary objective of the surgery is to control change or affect any emotional or behavioural disturbance in such an individual.

b) **"Non-therapeutic sterilization": as surgical sterilization primarily undertaken to control fertility and reproduction.**

c) **"Electro-convulsive therapy": the electrical induction of a grand mal seizure, utilizing the minimum amount of electrical energy necessary to induce a convulsion.**

MINISTRY RESPONSE Not accepted.

RATIONALE Conventional definitions already exist. Also, as noted in the Steering Committee's addendum, the definition of psychosurgery as defined by the Mental Health Act is sufficient. There appears to be no particular reason to define these terms in the regulations when the standard definitions are so widely known. These proposed definitions can be used as 'working definitions' in any training materials.

RECOMMENDATION

30. **The future Professional Advisory Board consult with appropriate Ministry and research bodies to develop a working definition of 'non-therapeutic medical and chemical experimentation'.**

MINISTRY RESPONSE Accept.

RATIONALE It is important for service providers and review teams to understand the difference between research and "non-therapeutic medical and chemical experimentation". The definition is presently unclear. It therefore makes sense for the PAB to develop a working definition of this term.

RECOMMENDATION

31. **Each service provider be required to develop Terms of Reference that ensure that the review team fulfill the functions of peer consultation and review, and human rights review. Such terms of reference shall be based upon procedural guidelines developed by the policy and program development branch of the Ministry in consultation with the Professional Advisory Board, and shall encompass such issues as objectives, composition, activities, and duties.**

MINISTRY RESPONSE Accept.

RATIONALE Terms of Reference are important to ensure that review teams fulfill their appropriate roles. Guidelines provided by the Ministry in consultation with the PAB will provide the consistency and flexibility necessary for strong functioning review teams across the Province.

RECOMMENDATION

32. **Review teams must follow the intent of the Child and Family Services Act, and ensure that children and their parents have an opportunity where appropriate, to be heard and represented when decisions affecting their interests are made and when they have concerns about the services they are receiving.**

MINISTRY RESPONSE Accept.

RATIONALE This is consistent with the intent of Part VI.

RECOMMENDATION

33. **Funds be made available for implementation of the review team mechanism with regard to:**

    (1) Reimbursement to service providers for professional fees and expenses for members of the review team not employed by the service provider.

    (2) Training and orientation costs for review team members.

MINISTRY RESPONSE Accept with the following provisos:

(1) A fee for service arrangement will be struck where the approved, external review team member cannot be obtained on a reciprocal basis.

(2) Initial training and orientation for review team members will occur with Part VI training. There is therefore no need for extra costs here.

RATIONALE In order for the review team to function, service providers will require funds to pay the fees and expenses of 'external' professionals who are members of the review team. This will only be necessary, however, where external members are not employees of

Ministry approved agencies.

RECOMMENDATION

34. A Professional Advisory Board shall be a regularly functioning body with responsibilities for monitoring and advising on such issues as set out in Section 128 and Section 129 of the Act, and shall be provided administrative support to perform these duties.

MINISTRY RESPONSE

Accept with the understanding that the 'monitoring' role is not a 'regulative' one, but rather a review of specific situations at the request of the Minister.

RATIONALE

The PAB is an essential safeguard provided in Part VI for the protection of children. The PAB will assist in maintaining up-to-date schedules on psychotropic drugs and intrusive procedures in addition to being available to give advice to or investigate complaints at the request of the Minister. In order to be effective the PAB must function regularly and be provided with administrative support.

RECOMMENDATION

35. The Professional Advisory Board be composed of:

.1 A roster of eight to twelve professionals who not only meet the statutory criteria for membership but are able to represent the interests and "realities" of service providers of various sizes and resources throughout the Province.

.2 Professionals in addition to the physician required, representative of law, nursing, psychopharmacology, psychiatry, psychology, child care, and social work.

.3 Members who serve for a term of three years.

.4 Membership that expires on a rotational basis.

MINISTRY RESPONSE

Accept in principle. It is understood that "ex-officio" members, including professional staff employed by the Ministry, may be called on from time to time for specialized advice with respect to particular issues.

RATIONALE

The proposed criteria provide the PAB with professional breadth, sufficient size to promote reasonable response time and the necessary expertise and reasonable consistency (given the rotating terms of office).

However, reference to "professionals who not only meet the statutory criteria for membership but are also able to represent the interests and 'realities' of service providers..." does not reflect the role of the PAB. It is set up to represent various professionals with expertise on the uses of extraordinary measures and who have "demonstrated an informed concern for the welfare and interests of children". It is not designed to represent the interests or realities of service providers, but rather, exclusively, the welfare and interests of children.

RECOMMENDATION

36. **The mandate for the Professional Advisory Board include a determination of what procedures are intrusive, and yearly review and alteration of the intrusive procedures schedule to the regulation.**

MINISTRY RESPONSE

Accept with understanding that the PAB's role is to advise the Minister on prescribing procedures as intrusive. The PAB in that sense does not determine which procedures are intrusive, it recommends a schedule to the Minister.

RATIONALE

This role is defined in Part VI.

RECOMMENDATION

37. **The mandate for the Professional Advisory Board to make, amend, suspend, and revoke approval of service providers to use intrusive procedures be conducted by formation of an approval panel, composed of selected representatives from the appropriate area or regional office, and representatives of the Professional Advisory Board. The approval panel is responsible to both the Regional Office of the Ministry of Community and Social Services and the Professional Advisory Board.**

MINISTRY RESPONSE

Not accepted. The mandate of the PAB is to advise the Minister.

RATIONALE

One fundamental safeguard contained in the intrusive procedures provisions in the CFSA is the requirement that the Minister approve settings for the use of such procedures. A further safeguard is that the review teams must approve (except in certain emergency situations) each specific procedure. A third safeguard is the existence of an advisory board available to advise the Minister on matters regarding the use of intrusive procedures. If the PAB were to approve procedures there would be no body of expert professionals available to review that approval. In order for section 129 to be effective the Minister must have available a PAB to review and investigate the use of intrusive procedures. Clearly the PAB could not review and investigate their own approvals. It is essential, therefore, for the PAB to remain in both an independent and an advisory capacity in order to provide this essential check and balance built into the system of safeguards.

RECOMMENDATION

38. **The Professional Advisory Board, in its role as an investigator and reviewer of situations and issues of concern around the use of psychotropic drugs and intrusive procedures, act as a professional advisory to the Ministry and not as a parallel monitoring body.**

MINISTRY RESPONSE

Accept with the understanding of the PAB's role as clarified in recommendation 37.

RATIONALE

See recommendation #37.

RECOMMENDATION

39. **The Professional Advisory Board be given responsibility for the analysis and review of the patterns of use of psychotropic drugs, intrusive procedures and secure isolation, and report these findings and any recommendations to the Minister yearly. As such, it is necessary to set out in regulation, the service providers' responsibility with regard to yearly reports on their use of extraordinary measures.**

MINISTRY RESPONSE

Accepted in principle. The PAB can be given full access to reports collected by the Ministry from the Review Team's regular reports. This data may be used by the PAB to analyze patterns of use of intrusive procedures and secure isolation. A practical way of

collecting data on the use of psychotropic drugs is not presently anticipated.

RATIONALE

Consistent with the response to recommendations #37 and #26, the PAB must remain advisory. Any role which includes service provider's responsibilities to the PAB would shift their role to a monitoring and regulative one. As noted earlier, this is to be avoided. The service providers and the review teams have responsibility to provide reports to the Ministry. The PAB will have access to the necessary data through the Ministry.

RECOMMENDATION

40. **On referral from the Minister, the Professional Advisory Board shall review and investigate the use of secure isolation, psychotropic drugs or intrusive procedures with an individual child at the request of any person, and in all situations of high risk intrusive procedure and for substitute consent for emergency use of psychotropic drugs for the 16/17 year old who lacks capacity and proxy consent.**

MINISTRY RESPONSE

Accept this recommendation only to: "of any person".

RATIONALE

The accepted part of this recommendation is the legislated role of PAB (Section 129). The latter parts change the role to a regulative one and consistent with the rationale from recommendations #26 and #37, this is not acceptable.

RECOMMENDATION

41. **The Professional Advisory Board Steering Committee assist the Ministry in the orientation and training of the following groups:**

    .1 **Review teams: The development of training materials and (procedural manuals) for the use of review teams as well as the implementation of this orientation and training. Such training materials should describe current professional and ethical practices.**

    .2 **Ministry personnel: This orientation would address definitions, currently accepted practices and procedures, and responsibilities for Part VI implementation to area office staff of the Ministry.**

    .3 **Service providers: Orientation and training in the use of intrusive procedures, secure isolation, and psychotropic drugs. This orientation would include discussion of preferred professional**

practices, definitions, supervision and monitoring of intrusive procedures, side effects and contra-indications, evaluation of the treatment, and consent.

MINISTRY RESPONSE

Accept with the understanding that the PABSC is in accord with the Ministry's view of the role of the PAB as set out in this document.

RATIONALE

Steering Committee members are knowledgeable professionals who can greatly assist Ministry personnel in the necessary training.

APPENDIX A

PROFESSIONAL ADVISORY BOARD
STEERING COMMITTEE MEMBERS

Dr. B. Goldberg (Chairperson)
Psychiatrist
CPRI
London

Dr. Susan Bradley
Psychiatrist
Hospital for Sick Children
Toronto

Dr. Alex. M. Bryans
Paediatrician
Health Sciences Offices of
Education
Queen's University
Kingston

Dr. Lois A. Dobson
Psychologist
Windsor Health Unit
Windsor

Dr. Charles Gowdey
Pharmacologist
Department of Pharm. and Tox.
University of Western Ontario
London

Ms. Dorothy Griffiths
(Vice Chairperson)
Director, Behaviour Management
York Central Hospital
Richmond Hill

Dr. Joel Hundert
Psychologist
Niagara Child Development Centre
Welland

Heather Katarynych
Senior Legal Counsel
Metro Children's Aid Society
Toronto

Dr. Martha Keller
Psychologist
University of Western Ontario
London

Dr. J. Sherman
Psychologist
Thistletown Regional Centre
Toronto

Dr. Frank Turner
Chairman
Department of Social Work
Atkinson College, York University

Brian Weagant
Barrister and Solicitor
Toronto